REPORT OF TARGET EXAMINATION
QualMed Washington Health Plan, Inc.
As of March 31, 1998

CHIEF EXAMINER'S AFFIDAVIT

I hereby certify that the attached Report of Target Examination shows the financial condition and affairs of QualMed Washington Health Plan, Inc., of Bellevue, Washington, as of March 31, 1998.

JAMES T. ODIORNE, CPA, JD
Deputy Insurance Commissioner
Acting Chief Examiner

1/7/99

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QualMed Washington Health Plan, Inc.

December 11, 1998

Honorable Deborah Senn
Washington Insurance Commissioner
Insurance Building
PO Box 40255
Olympia, Washington 98504-0255

Dear Commissioner Senn:

Pursuant to your instructions and in compliance with the requirements of the State of Washington, a Target Examination has been made of the corporate affairs and financial records of:

QualMed Washington Health Plan, Inc.
of
Bellevue, Washington

hereafter referred to as the Company or QualMed at its home office located at 2331 130th Avenue NE, Suite 200, Bellevue, Washington 98009-9338.

SCOPE

Our target examination included the business affairs and financial condition of the Company as of March 31, 1998. The examination was performed in accordance with procedures promulgated by the National Association of Insurance Commissioners (NAIC) for limited scope examinations and in compliance with the provisions of Washington state insurance laws and regulations. A limited scope examination is not intended to communicate all matters of importance for an understanding of the Company's financial condition, but only those areas perceived to be a problem or a potential problem as identified in the objectives portion of this report.

OBJECTIVES

1. Examine areas assessed to have a high probability of risk of material misstatement as determined by the preliminary planning phase. The Findings, Instructions and Recommendations section of the Target Report address those areas.
2. Determine the adequacy of internal controls and the reliance that can be placed on the Company's accounts and records.
3. Review the Company's claims processing to determine the reason for delayed claims and

consumer complaints of denied claims.

4. Review Company compliance with Washington state statutes, regulations and NAIC guidelines pertaining to the compilation and reporting of the annual statement.
5. Verification of existence and ownership of the Company's assets supporting the policyholder claims and other liabilities.
6. Review subsequent events to assess contingent liabilities, risk exposure and material operational changes.

CONCLUSION

Our target examination of the Company disclosed areas of non-compliance and specific areas where reporting and control weaknesses exist in its accounting systems. These are shown in their respective parts of the target examination. The control weaknesses encountered appear to be specific to the areas directly related to the complexities of compilation and reconciliation of financial and other data on two separate health care systems, AMISYS and MSI. In addition, the AMISYS system does not generate the necessary reports to age premium receivables and calculate an allowance for doubtful accounts.

The Company is instructed to correct the specific system and control deficiencies as noted in this report, and it is recommended that QualMed review its system reporting requirements and controls to ensure accurate filing of financial data as required by RCW 48.46.080. Our findings indicate that QualMed is a medium to high priority company that should be closely monitored and scheduled for a full scope examination, when resources are available, to ensure compliance to the instructions contained within this Target Report.

FINDINGS, INSTRUCTIONS AND RECOMMENDATIONS

1. Overstatement of Admitted Assets - Provider Receivables

QualMed has capitated contracts with providers to provide health care services to enrollees. QualMed has paid one month advance capitation to these providers. In addition to the one month advance capitation, QualMed has advanced $5,128,728 additional funds, on a personal security basis to these capitated providers for processing and paying claims on the provider's behalf. These claim amounts are deducted from future capitation payments. Per RCW 48.12.020(3) "...advances to other *persons* on personal security only" are expressly non-admitted assets. *Persons* are defined as any individual, company, insurer, association, organization, etc. under RCW 48.01.070. The examination adjustment to non-admit provider receivables as of March 31, 1998 is $ 5,128,728. (See Summary of Adjustments 1)

Instruction 1

QualMed is instructed to account for its net worth as defined by RCW 48.46.020(18) and non-admit all provider receivables in all future filed statutory statements. Net worth is defined as the excess of total admitted assets, as defined in RCW 48.12.010, over liabilities. RCW 48.12.010 specifically lists which assets qualify under the above definition. QualMed's claim payment advance arrangement to capitated providers does not meet this definition of an asset; and is expressly a non-allowable asset as defined in RCW 48.12.020(3). In addition, the Commissioner has found that these types of advances may not be available for the payment of claims.

2. Unrecorded Liabilities - Accounts Payable

A search for unrecorded liabilities was conducted on a judgmental basis on checks written from the Company's operating account for the period April 1, 1998 through August 31, 1998. The criteria used for the review was as follows:

I. All checks over $5,000 dollars for the period April 1, 1998 through April 30, 1998.
ii. All checks over $10,000 dollars for the period May 1, 1998 through June 30, 1998.
iii. All checks over $25,000 dollars for the period July 1, 1998 through August 31, 1998
iv. Judgementally reviewed disbursements that were assessed with a high probability of being unrecorded.

Our sample detected a $670,621 dollar under accrual of accounts payable as of March 31, 1998. An examination adjustment to increase accounts payable was posted to reflect the unrecorded liability and to reduce net worth by a corresponding amount. (See Summary of Adjustments 2)

Instruction 2

RCW 48.46.080 requires the accurate filing of the annual statement and supplements. The Company is instructed to review and enhance controls to ensure the proper identification and recording of all liabilities and expenses per the NAIC Annual Statement Instructions as required under WAC 284-07-050(2).

3. Cash

The Company's cash reconciliations are extremely lengthy and cumbersome. In some cases the reconciling and reclassification adjustments had no back up or support. After considerable effort we were able to obtain support and test the material reconciling items. Several internal control deficiencies were noted that contributed to the difficulty in examining the cash accounts. These are as follows:

I. No supervisory review and/or approval of bank reconciliations

ii. General ledger balances did not agree to bank reconciliations
iii. No overall reconciliation of total cash per general ledger to total cash per bank statements is performed.
iv. Adjustments and reclassifications are not discovered and/or posted in a timely manor.

Our review indicated that cash was overstated by $373,648 due to a reconciling item in 1997 that was erroneously corrected in January 1998, causing the reconciling item to double in magnitude. The error had not been corrected in the cash account for the period ended March 31, 1998. This error had a corresponding understatement effect to premiums receivable. No reclassification is recommended because the error had no effect on net worth.

Instruction 3

RCW 48.46.080 requires the accurate filing of the annual statement and supplements. The Company is instructed to review and enhance controls to ensure the proper identification, recording and timely reconciling of all cash accounts.

4. Claim Reserve and Disbursement Analysis

Claim reserve and disbursement analyses were conducted in order to verify the integrity of paid claims data used in our reserve adequacy testing and to determine the main reason(s) for complaints filed with the Office of the Insurance Commissioner for slow or non-payment of claims. The following are the results of our analysis:

Claim payment delays

Our analysis of the claims processing functions (Service Center in Pueblo) indicated that the delays have been caused primarily by the following:

I. Setting the automatic computer edits extremely tight in the AMISYS and MSI systems which pended claims that did not pass the edits. Approximately 75% of all claims are pended and must be manually adjudicated by claims personnel. This has caused lengthy time delays in the payment of claims.

ii. It also appears the Company automatically denies claims that do not have all the proper paper work attached or are incomplete for other reasons. QualMed puts the onus on providers and subscribers without doing much follow up, whether or not the claim is legitimate. This probably accounts for a significant portion of complaints made against the Company.

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Instruction 4

Pursuant to RCW 48.01.030, the Company is instructed review claim adjudication procedures to ensure it is acting in good faith and no material breaches of its obligation to provide required health care services to enrolled participants has, or is occurring, as defined by WAC 284-30-330.

Unpaid Claims

A review of claim reserves was conducted by our OIC Actuarial Analyst, Lichiou Lee. Ms. Lee indicated the Company was over reserved by approximately 10% on March 31, 1998. The paid claims data in reported Sch 'H' for the 1996 and 1997 Annual Statement filings for QualMed were reconciled without material exception to the raw paid claims data supplied. The following schedule illustrates Ms. Lee's estimates of reserve adequacy for the following periods:

December 31, 1997	20% over reserved
March 31, 1998	10% over reserved
June 30, 1998	4% over reserved

Ms. Lee's analysis indicates a downward trending of reserve adequacy for unpaid claims. A 10% margin of reserve over expected claim run out is a conservative and prudent level to cushion the Company through unexpected negative deviations in claim experience. It is recommended the Company review its claim reserving methodology in order to mitigate or reverse the downward trend.

Claim testing

We randomly selected a sample of 330 paid claims for the first quarter of 1998. Statistically, this should give us a 95% confidence level. The population was approximately 250,000 records. The testing was conducted in order to verify the accuracy of QualMed's claim processing system and claim data integrity. We tested date of service, date of payment and payment amount.

In addition, our review of the Colorado Service Center indicated reported date data to be unreliable. QualMed has a policy of reassigning new reported dates to any claims that are denied and re-input.The new reported date used is the date at the time the denial is reinstated.

Our testing of actual claims indicated that we could rely on the data input into the QualMed system for our reserve work. We had no material discrepancies between the actual claim service (incurred) dates and paid amounts to the reported incurred dates and amounts in the Company's system. The discrepancies noted in reported dates were not deemed material for our reserve work.

Instruction 5

Pursuant to RCW 48.46.080, the Company is instructed to review the claim tracking procedures to identify the initial reported dates in order to identify the time lag between reported to paid dates accurately. This will ensure the proper accounting of the reported but not paid portion of claim reserves.

5. Subrogation

The Company does not have formal subrogation procedures. At this time, the Company does not investigate claims that might be covered under Auto Personal Injury Protection and Worker's Compensation. It is recommended the Company institute formal subrogation guidelines to recover claim costs under third party liabilities.

6. Provider contracts

QualMed has agreements with some provider groups that do not have provider contracts with the subproviders supplying non-emergent, in area covered services to QualMed subscribers. Per RCW 48.46.243(1), "...every contract between a health maintenance organization and its participating providers of health care services shall be in writing..." and WAC 284-46-575(3) further states use "of a participating provider contract shall include, but not be limited to, execution by the health maintenance organization or the provider, effectuating the terms of the contract, or referring enrolled participants to the provider for non-emergent, in area covered services." (See subsequent event 1)

Instruction 6

QualMed is instructed to review all medical delivery systems to ensure all providers are contracted under approved participating provider contracts pursuant to RCW 48.46.243. This would include any subprovider arrangements entered into with third party administrators under capitation arrangements which must comply with the hold harmless provisions of WAC 284-46-575(4)(f).

7. Investment analysis

The Company's investment portfolio consists primarily of corporate bond issues and United States Government securities. The purpose of the review of investments was to establish existence and ownership of the assets supporting unpaid claim and other liabilities reported on the Company's financial statements. Our review verified the existence and valuation of those investments without material exception for the period ended March 31, 1998.

8. Premium receivables

QualMed is experiencing difficulties obtaining accurate and reliable information from the premium receivable aging reports produced by the AMISYS system. As a result, QualMed has had difficulty in estimating an allowance for doubtful accounts. Presently, a subjective analytical approach is used with different criteria for each group. The following problems were encountered in our review:

I. Premiums billed in advance and unearned are included in the report but are not actually receivable until the following month. Manual adjustments are needed to back out these premiums and the corresponding unearned premiums to accurately reflect the premiums receivable.

ii. Premium receipts are applied to the oldest open unpaid billing period. Sometimes this results in improper posting to billing periods. This causes reconciling problems due to changes in eligibility and other factors which change the monthly premium billing.

iii. A monthly comparison of billed versus paid is made for the largest groups and the difference is booked to the Allowance for Doubtful Accounts. This methodology would more closely reflect changes in eligibility, not doubtful accounts. In addition, this monthly tracking on a cumulative basis appears to be difficult, tedious and subject to inaccuracies.

QualMed Corporation, the parent company, provided the AMISYS System and assisted with its installation. Per the terms of the Intercompany agreement, QualMed Corporation is responsible for maintaining the system. QualMed Corporation is are aware of the AMISYS system inaccuracies but has not corrected these problems.

Instruction 7

RCW 48.46.080 requires the accurate filing of the annual statement and all supplements. The Company is instructed to identify and develop procedures with QualMed Corporation to correct the system and reporting deficiencies to accurately record premium receivables, aging of receivables and develop objective methodologies to estimate an allowance for doubtful accounts.

9. Intercompany Transactions

In its 1997 Annual Statement, QualMed has netted together the account receivable and account payable balances from the various affiliated companies. The netting of receivable and payable balances from affiliated companies does not comply with NAIC Annual Statement Instructions, which require receivables and payables from affiliated companies to be reported on a non-netted basis.

Instruction 8

RCW 48.46.080 requires the accurate filing of the annual statement and supplements. QualMed is instructed to comply with the accounting practices and procedures in compliance with the NAIC HMO Annual Statement Instructions pursuant to WAC 284-07-050(2). All intercompany payable and receivable balances must be reported separately.

10. System Reporting Deficiency - Public Employee Benefit Board (PEBB) contract

In 1996, QualMed began to process claims on two separate health care claim systems, AMISYS and MSI. In 1997, QualMed reprogrammed a report to combine the claim data from both systems. This report was used to submit the 1996 PEBB claim contract activity to the Washington State Health Care Authority (HCA) to recalculate the health status risk adjustment. The health status risk adjustment is used to calculate future premiums on PEBB business.

The new program successfully captured the AMISYS data but did not merge the MSI data into the report. The reporting error was not discovered by management until the Spring of 1998. This reporting deficiency led to a material omission and the submission of erroneous claim data to the HCA. QualMed estimates the error will materially reduce 1998 premium income on PEBB business by approximately $1.8 to $1.9 million dollars.

Instruction 9

Pursuant to RCW 48.46.080, the Company is instructed to review and enhance its controls and reporting systems to ensure the proper recording of all PEBB contract data.

11. Summary of adjustments

			Examination Adjustment
Total net worth 3-31-98	$	10,846,804	
Examination adjustments			
Provider Recievables		(5,128,718)	1
Accounts Payable		(670,621)	2
Adjusted total net worth 3-31-98	$	5,047,465	

QualMed Washington Health Plan, Inc.

QUALMED WASHINGTON HEALTH PLAN, INC
STATEMENT OF ASSETS, LIABILITIES, AND NET WORTH
MARCH 31, 1998

	BALANCE PER COMPANY	EXAMINATION ADJUSTMENTS	BALANCE PER EXAMINATION	EXAM ADJUSTMENT
CURRENT ASSETS:				
Cash and Short-term Investments	$ 17,304,685	$ -	$ 17,304,685	
Premiums Receivable	7,310,261	-	7,310,261	
Investment Income Receivables	172,653	-	172,653	
Health Care Receivables	1,407,122	-	1,407,122	
Amounts Due from Affiliates	1,181,479	-	1,181,479	
Aggregate Write-ins for Current Assets	5,964,768	(5,128,718)	836,050	1
TOTAL CURRENT ASSETS	33,340,968	(5,128,718)	28,212,250	
OTHER ASSETS:				
Restricted Cash and Other Assets	1,207,209	-	1,207,209	
Bonds	12,259,784	-	12,259,784	
TOTAL OTHER ASSETS	13,466,993	-	13,466,993	
PROPERTY AND EQUIPMENT:				
Furniture and Equipment	1,023,045	-	1,023,045	
TOTAL PROPERTY AND EQUIPMENT	1,023,045	-	1,023,045	
TOTAL ASSETS	$ 47,831,006	$ (5,128,718)	$ 42,702,288	
LIABILITIES AND NET WORTH				
CURRENT LIABILITIES:				
Accounts Payable	$ 5,489,929	$ 670,621	$ 6,160,550	2
Claims Payable (Reported and Unreported)	30,708,737	-	30,708,737	
Unearned Premiums	785,536	-	785,536	
TOTAL CURRENT LIABILITIES	36,984,202	670,621	37,654,823	
TOTAL LIABILITIES	$ 36,984,202	$ 670,621	$ 37,654,823	
NET WORTH:				
Common Stock	100,000	-	100,000	
Paid in Surplus	6,755,985	-	6,755,985	
Retained Earnings/Fund Balance	3,990,819	(5,799,339)	(1,808,520)	
TOTAL NET WORTH	10,846,804	(5,799,339)	5,047,465	
TOTAL LIABILITIES AND NET WORTH	$ 47,831,006	$ (5,128,718)	$ 42,702,288	

QualMed Washington Health Plan, Inc.

SUBSEQUENT EVENTS

Events or occurrences that have or could have a material impact on the financial position of QualMed after the target examination date of March 31, 1998, are included in the subsequent events section of this report.

Healthlink - Chapter 11 Bankruptcy Protection

Background:

In July of 1997, QualMed entered into capitation arrangements with Northwest Medical Services Organization (NMSO) and Northside Physician Hospital Network (NPH) to cover Medicare subscribers in the Spokane, Washington area. NMSO and NHP contracted with Healthlink to administer these contracts. Healthlink is a Washington Nonprofit Miscellaneous and Mutual Corporation. NMSO and its member physicians control Healthlink through Class A and Class B membership. In May 1998, QualMed entered into a second capitation agreement with NMSO and NPH, administered by Healthlink, to cover commercial and healthy options subscribers. QualMed retained the pharmacy portion risk on the second capitation agreement.

In July 1998, QualMed received reports indicating Healthlink was having difficulties paying claims in a timely fashion. QualMed requested an audit to be performed by Deloitte &Touche, Certified Public Accountants, to attest to the financial stability of the organization. After the audit, the Chief Financial Officer of Healthlink was terminated in September 1998 for failure to maintain adequate records. Healthlink has acknowledged a substantial operating deficit for both 1997 and 1998, estimated at $4.7 million and $9.8 million, respectively. As of November 1998, Healthlink filed for Chapter 11 protection.

Healthlink administered approximately 18,500 QualMed subscribers with about $2 million in capitated revenues per month. In October 1998, QualMed announced termination of the capitation agreements as of October 31, 1998. As of November 1, 1998, QualMed reverted back to fee-for-service arrangements with those providers using Healthlink who chose to contract directly with QualMed.

Potential exposure:
Healthlink in some instances used non-contracted providers to deliver health care services to QualMed's enrollees for in area, non-emergent covered services. Empire Health group which includes two Spokane area hospitals, Deaconess and Valley General, provided services to QualMed enrollees without a contract. QualMed indicated it withheld the October 1998 capitation payment to Healthlink until confirmation of Healthlink's claim payments to Empire Health could be substantiated. QualMed may have potential exposure for claims to non-contracted providers that

QualMed Washington Health Plan, Inc.

Healthlink has not paid. Until all claims are finalized, QualMed does not know the dollar magnitude of the potential exposure for outstanding claims. (See Instruction 6)

In addition, QualMed President, Chris duLaney has indicated there are contracted providers that have not been paid by Healthlink. The Company believes it will not be liable for those claims administered by Healthlink.

QualMed Washington Health Plan, Inc.

AFFIDAVIT

STATE OF WASHINGTON }
} **ss**
COUNTY OF KING }

Michael V. Jordan, CPA, CFE, being duly sworn, deposes and says that the foregoing report subscribed by him is true to the best of his knowledge and belief.

He attests that the examination of QualMed Washington Health Plan, Inc., was performed in a manner consistent with the standards and procedures required or prescribed by the Washington Office of Insurance Commissioner and the National Association of Insurance Commissioners (NAIC).

Michael V. Jordan, CPA, CFE
Examiner-in-charge
State of Washington

Subscribed and sworn to before me this 7th day of January, 1999.

Notary Public in and for the
State of Washington.